MARYLAND DEPARTMENT OF HUMAN RESOURCES MEDICAL REPORT FORM

Department of Social Services Name and Address	
Return to LDSS by:	LDSS Fax Number:
Case Manager E-mail Address:	

Agency Use Only- CASE IDENTIFICATION	
CUSTOMER ID NUMBER	DIST
CASE NAME	

This medical report is needed to determine one or more of the following:

- Whether an individual is able to participate in employment and/ or training activities,
- Applicable, treatment plan(s) that could help the individual move towards employment,
- If the individual is a good candidate for disability assistance, and
- If applicable, whether the individual's pregnancy limits or precludes participation in employment or training activities.

COMPLETED BY THE DEPARTMENT OF SOCIAL SERVICES		
Customer's Name:	Customer's DOB:	Customer's Phone #:
Customer's Address (Street, City, Zip Code)		

Instructions to Health Provider

This form may be completed by a licensed health provider such as counselor, social worker, or mental health therapist, but must be agreed upon and signed by a licensed physician, psychiatrist, physician's assistant or a Certified Registered Nurse Practitioner.

Please complete the appropriate sections of this form and send (return to the patient or mail, fax or e-mail to case manager) to the Department of Social Services office above by _____.

Confirmation of Pregnancy

If this individual is pregnant, give expected delivery date. _____/_____/_____.
Date

Note: If pregnancy does not affect this individual's ability to work, only complete health provider section of this form.

SECTION I HEALTH PROVIDER INFORMATION — PLEASE COMPLETE THIS ENTIRE SECTION.

Printed Name of Health Provider: _____

License Number: _____ NPI Number: _____
(If Applicable)

Phone Number: (_____) _____ Address: _____

_____

I certify that all of the information provided on this form is true, correct and complete to the best of my professional knowledge. I further certify that, the diagnosis and assessment related to this customer's health condition are based on his/her medical condition as determined by examination and knowledge of this customer's medical history.

Signature of medical provider must be original or the form is invalid. Rubber stamp, label or other reproductions are not acceptable.

_____ _____
Health Provider Date

_____ _____
Signature of Medical Provider Date

DHR/FIA 500 Medical Report Form Revised 4/13
Obsoletes all prior versions and 402P

Customer's ID # _____ Customer's Name_____ Date of Birth_____

SECTION II EMPLOYABILITY

If BOX 1 IS SELECTED FOR THIS INDIVIDUAL, DO **NOT** COMPLETE SECTION III.
IF EMPLOYABLE, THIS INDIVIDUAL WILL HAVE A REQUIREMENT TO WORK OR PARTICIPATE IN TRAINING FOR _____ HOURS PER WEEK.
PLEASE SELECT ONE OF THE FOLLOWING BASED ON YOUR BEST ESTIMATE OF THE INDIVIDUAL'S CURRENT CAPABILITIES:

1. ☐ **EMPLOYABLE** –

   This individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above).

   ☐ with the following reasonable accommodations: _____
   _____

2. ☐ **LIMITED EMPLOYABILITY – Please check all that apply. Please also complete Section III**.

   This individual is able to work or participate in training, on a sustained basis, for fewer than the hours that are required per week (see above).
   Approximately how many hours can the individual participate per week? _____

   ☐ with the following reasonable accommodations: _____
   _____
   _____

   What is the recommended treatment plan to remediate this condition so this individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above) or to increase the hours of participation?

   ☐ Prescribed Medication
   ☐ Therapy: _____ hours per week. Type: _____
   ☐ Follow-up with specialist: Specialty _____ Name of Physician _____
   Referral Made for Patient? _____
   ☐ Is substance abuse present? ____Yes ____ No
   If yes, do other medical conditions exist in addition to substance abuse? _____Yes _____ No
   ☐ Other (describe): _____

   This individual is expected to be limited from being able to work or participate in training for the number of hours indicated above on a sustained basis, beginning _____/_____/_____ and ending _____/_____/_____.
   Date **Date**

3. ☐ **TEMPORARY INCAPACITY – Please also complete Section III.**

   This individual's physical or mental condition precludes him/her from participating in any form of employment or training activity, on a sustained basis, at this time, but the condition is expected to improve within 12 months.

   This individual's temporary incapacity is expected to prevent working or participation in training beginning _____/_____/_____ and ending _____/_____/_____.
   Date Date

   What is the recommended treatment plan to remediate this condition so this individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above) or to increase the hours of participation?

   ☐ Prescribed Medication
   ☐ Therapy: _____ hours per week. Type: _____
   ☐ Follow-up with specialist: Specialty _____ Name of Physician _____
   Referral Made for Patient? _____
   ☐ Other (describe): _____

4. ☐ **DISABLED – Please also complete Section III**.

   This individual has a physical or mental condition that is expected to last for 12 months or more, and precludes any form of employment, on a sustained basis, of at least 30 hours per week. The individual is a candidate for Social Security Disability or Supplemental Security Income.

   The disability begin date _____/_____/_____ and end date _____/_____/_____.
   Date Date

Customer's ID #_____ Customer's Name_____ Date of Birth_____

SECTION III DIAGNOSIS (ES)

Include name of each diagnosis with ICD-9 code and description. Please explain how each diagnosis affects the customer's ability to work.

Primary Diagnosis:

Secondary Diagnosis:

Tertiary Diagnosis:

Other Diagnosis:

The individual is following the prescribed treatment plan.

_____Yes _____ No _____ Don't know If No, indicate:

- ☐ Not taking medication as prescribed.
- ☐ Not following up with specialist
- ☐ Not eligible or appropriate for needed medication or treatment . Explain: _____

_____

_____

- ☐ Other (describe): _____

_____

_____

_____

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